ISDH HSP Substance Abuse Outpatient Care Service Standard

HRSA Service Definition:

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder
  - Medication assisted therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

Program Guidance:

- Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan.
- Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific guidance.

Key Services Components and Activities:

Substance Abuse Outpatient Care is provided by or under the supervision of a physician or other qualified/licensed personnel and provides services as outlined in the service definition to persons screened, assessed and diagnosed with a substance use disorder. This service may include use of funds to expand HIV-specific capacity of programs if timely access to treatment and counseling is not otherwise available. Key services components and activities are noted in the Service Standards below.

HSP Service Standards:

Standard	Documentation
1. Personnel Qualifications	
1. Staff must meet one or more of the following qualifications: a) A master's degree in counseling, social work, psychology, or another closely related discipline in addition to valid licensure and certification as substance use treatment professionals issued by one of the following: i) The Indiana Behavioral Health and Human Services Licensing Board ii) The Indiana State Psychology Board A. Staff that do not possess licensure or certification from the aforementioned licensing boards must possess a degree in counseling, social work, psychology, or another closely	1. Documentation of all applicable licensures, certifications, education is available for review Documentation of continuing education, at minimum 10 hours per year

related discipline, and be supervised by an individual that is licensed by one of the aforementioned boards OR b) Be a certified peer recovery specialist 2. Providers must obtain continuing education according to the appropriate licensing board, or at minimum 10 hours of substance abuse-specific training per year.	
2. Eligibility Criteria	
1. Subrecipients must have established criteria for the provision of substance abuse outpatient care that includes, at minimum: • Eligibility verification consistent with recipient requirements	1. Non-medical case managers must maintain up to date eligibility records for clients according to agency protocol and in any data system required by ISDH. 2. Service providers and sub-recipients must maintain documentation of current eligibility if providing HIV services reimbursable under the RWHAP Part B Program. • Acceptable documentation includes a current eligibility approval letter dated within 6 months of service provision. These letters may be accessed from the client's Non-medical case management, and includes effective and end dates of eligibility and those services for which the client may enroll. 3. Documentation must be made available for review by ISDH upon request.
3. Intake	
1. Client will be contacted to schedule an intake within 5 business days, and client's intake appointment will be completed within 10 business days of client's initial contact to agency. Subrecipients will have a protocol in place for responding to more time-sensitive emergencies. 2. In the event of any delay to accessing care (including delays due to the client's stage of recovery readiness), reasonable attempts will be made to maintain communication with the client for the purpose of preserving engagement with the substance abuse treatment system.	1. New client charts will have an individual intake completed within 10 business days of client's initial contact to agency. If intake was not completed within 10 days of client's initial contact to agency, the reason will be documented in the client's record. 2. Documentation of protocol to respond to time-sensitive emergencies 3. Client record documentation includes evidence of reasonable contact attempts with clients that have had delayed access to care.
4. Assessment	
1. Each client receives a formal assessment upon entry into substance use treatment within the first two sessions, except when documented	1. Client record documentation includes a written assessment completed during the first or

reasons exist that preclude this standard from being met. 2. Evidence-based diagnostic tools will be used when needed to assess for suspected substance use disorder diagnoses. 3. Client assessments will include, at a minimum: • Substance use history and current use • Suicidal ideation • Appropriateness of referral for psychiatric needs • Dual diagnoses • Mental health and substance abuse treatment history • History of trauma • Functional needs • Medical needs, including medically-monitored detoxification 4. The diagnosed substance use disorder, as identified in DSM-5, that will guide treatment	second session and, if completed after the second session, an explanation for the delay. 2. Subrecipient assessment tool/form must include, at minimum: • Suicide ideation; • Crisis needs; • Medication history; • Appropriateness of referral for psychiatric needs; • Substance use history and current use; • Treatment recommendations; • Mental health treatment history; and • Sexual and drug use risk-taking behavior 3. Client record documentation includes a substance use disorder diagnosis if treatment is indicated
5. Service Delivery/Treatment	
1. Providers deliver the appropriate level of service for the client based on the client's ability and willingness to participate, and providers immediately refer clients for whom the services offered are not suitable. 2. Providers create or adapt an individualized, written treatment plan within two visits for each client. Every plan includes: • A description of the need(s); • The treatment modality; • Start date for substance use treatment services; • Recommended number of sessions; • Date for reassessment; • Any recommendations for follow-up • Provider and client signature 3. Notes in the service record reflect progress on and recommended updates to the treatment plan, as well as any collaborations or information exchanges that have taken place with other providers and members of the treatment team 4. Efforts are made to engage and maintain clients in primary care 5. The mental health/substance abuse treatment provider coordinates medication management with primary care and other prescribing providers as appropriate	1. Client record documentation includes: • Client referral to appropriate services, if applicable • Client Treatment Plan • Signed and dated progress notes demonstrating counseling and services consistent with Treatment Plan • Signed and dated progress notes addressing engaging and maintaining clients in care, including any coordination of medication management

6. Staff follow-up with clients who miss scheduled visits to address barriers and reschedule the appointment, communicating with other providers, (including case managers) as needed to maximize retention in care	
6. Discharge	
1. Reasons for case closure are documented when applicable. Notes reflect attempts to provide continuity of care (such as linkage with another service, attempts to contact client, referrals made for or on behalf of client, or a plan for after-care) prior to closure. Allowable reasons for closure include: • The client has requested termination of services; • Goals of the treatment plan have been achieved (upon mutual agreement by provider and client); • The client has elevated to a higher level of care (i.e. in-patient/residential substance abuse treatment) • The client has moved out of the service area or is otherwise no longer eligible; • The agency has had no contact with the client for 12 months or more; or • The client is deceased.	1. Client record documentation notes reason for case closure and appropriate referrals if indicated

Subservices:

- Substance Abuse Services Outpatient- Initial Visit including assessment
- Substance Abuse Services Outpatient- Follow-up individual counseling visit
- Substance Abuse Services Outpatient- Follow-up group counseling visit

Service Unit Definition:

- Unit = 1 visit